EXHIBIT "8"

EXHIBIT "8"

INDEX

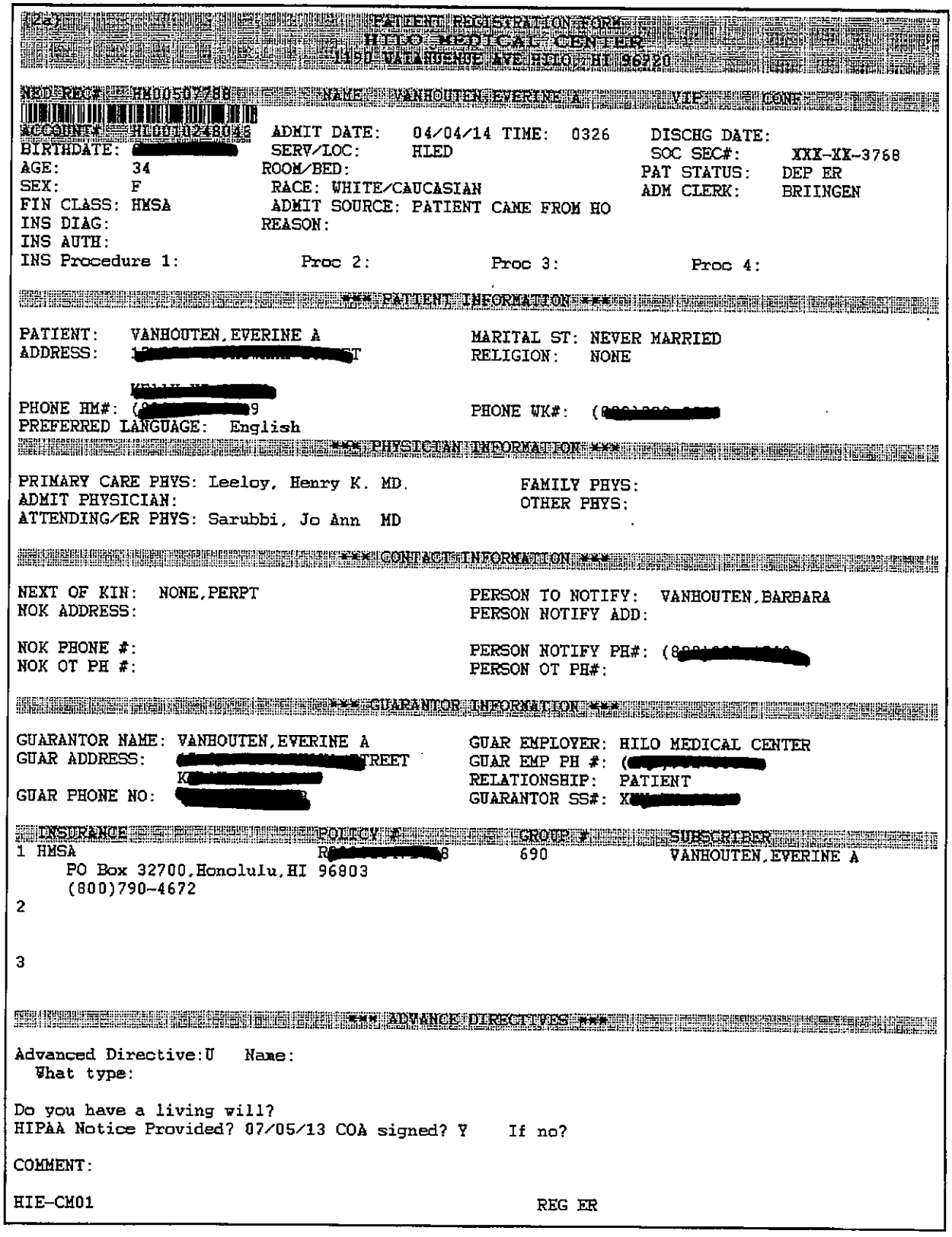
Footnote 30: (BS) Nos. 177-183

Footnote 31: (BS) Nos. 169-170, 174-175

Footnote 32: (BS) Nos. 134-140

Footnote 33: (BS) Nos. 129-131, 82-88, 54-56

FOOTNOTE 30



PATIENT REGISTRATION FORM
HILO MEDICAL CENTER
1190 WAIANUENUE AVE HILO, HI 96720

MED REC#: HM00507788 NAME: VANHOUTEN,EVERINE A VIP: CONF:

ACCOUNT#: HL000024804[redacted] ADMIT DATE: 04/04/14 TIME: 0326 DISCHG DATE:
BIRTHDATE: [redacted] SERV/LOC: HLED SOC SEC#: XXX-XX-3768
AGE: 34 ROOM/BED: PAT STATUS: DEP ER
SEX: F RACE: WHITE/CAUCASIAN ADM CLERK: BRIINGEN
FIN CLASS: HMSA ADMIT SOURCE: PATIENT CAME FROM HO
INS DIAG: REASON:
INS AUTH:
INS Procedure 1: Proc 2: Proc 3: Proc 4:

*** PATIENT INFORMATION ***

PATIENT: VANHOUTEN,EVERINE A MARITAL ST: NEVER MARRIED
ADDRESS: 1[redacted]T RELIGION: NONE

[redacted]
PHONE HM#: ([redacted]9 PHONE WK#: ([redacted]
PREFERRED LANGUAGE: English

*** PHYSICIAN INFORMATION ***

PRIMARY CARE PHYS: Leeloy, Henry K. MD. FAMILY PHYS:
ADMIT PHYSICIAN: OTHER PHYS:
ATTENDING/ER PHYS: Sarubbi, Jo Ann MD

*** CONTACT INFORMATION ***

NEXT OF KIN: NONE,PERPT PERSON TO NOTIFY: VANHOUTEN,BARBARA
NOK ADDRESS: PERSON NOTIFY ADD:

NOK PHONE #: PERSON NOTIFY PH#: ([redacted]
NOK OT PH #: PERSON OT PH#:

*** GUARANTOR INFORMATION ***

GUARANTOR NAME: VANHOUTEN,EVERINE A GUAR EMPLOYER: HILO MEDICAL CENTER
GUAR ADDRESS: [redacted]TREET GUAR EMP PH #: ([redacted]
K[redacted] RELATIONSHIP: PATIENT
GUAR PHONE NO: [redacted] GUARANTOR SS#: X[redacted]

	INSURANCE	POLICY #	GROUP #	SUBSCRIBER
1	HMSA PO Box 32700,Honolulu,HI 96803 (800)790-4672	R[redacted]8	690	VANHOUTEN,EVERINE A
2				
3				

*** ADVANCE DIRECTIVES ***

Advanced Directive:U Name:
What type:

Do you have a living will?
HIPAA Notice Provided? 07/05/13 COA signed? Y If no?

COMMENT:

HIE-CM01 REG ER

Hilo Medical Center
We Care for Our Community
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)932-3000

Report Status: Signed

Patient: **VANHOUTEN,EVERINE A**
DOB: [redacted]
Medical Record: **HM00507788**
Account: **HL0010248046**
PCP: **Henry K. Leeloy MD**
ED Provider: **Sarubbi, Jo Ann MD**
Service Date: **04/04/14**

History of Present Illness
Nursing Note: Agreed With
Chief Complaint: Nausea/vomiting
Time Seen by Provider: 04/04/14 03:55
Source: Patient
Historian: Appears accurate
Exam Limitations: None
Notes: (location/quality/context):

Nursing Triage Note

History of Chief Complaint Pt recently had UTI, finished abx course. also c

/o nausea/vomiting

04/04/14 03:57
The patient presents to the emergency room department with right flank pain is radiating to her abdomen and lower pelvic discomfort associated with the nausea and vomiting. The that has been ongoing x2 days. The patient recently had a urinary tract infection and finished a course of antibiotics. She noted that she had blood in her urine today. Pain level is a 6/10.
Onset: Days
Severity: Moderate
Timing/Duration: Constant
Modifying Factors: improves with: Medication
Associated Symptoms: Nausea/Vomiting (A)
Allergies/Adverse Reactions:

No Known Allergies Allergy (Verified 04/04/14 03:32)

Home Medications:

Medication	Instructions	Recorded	Type
Ciprofloxacin HCl [Cipro 500 mg Tab*]	500 mg PO Q12H #10 tablet	04/04/14	Rx
Hydrocodone/Acetaminophen [Vicodin	1 each PO Q6HP PRN #14 tablet	04/04/14	Rx

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

5-300Mg Tablet]			
Ondansetron [Zofran ODT Tab]	4 mg PO Q6H #14 tablet	04/04/14	Rx

Past Medical History
Past Medical History: Reports: Other (Migraines; Possible choledocholithiasis w/ERC performed on 8/07/13). Denies: Asthma, DM, HTN
Past Surgical History: None
Last Menstrual Period: 1 month

- Social History
Personal History: Single
Alcohol: Reports: Occasional
Drugs: Reports: Never
Smoking Status: Never Smoker

Review of Systems
Except as noted: Reviewed and negative
Constitutional: Chills. denies: Fever
Gastrointestinal: Abdominal Pain, Nausea, Vomiting
Genitourinary: Hematuria. denies: Frequency, Dysuria, Vaginal Discharge
Neurological: denies: Dizziness

Physical Exam
Nursing Vital Signs:

Initial Vital Signs

Temperature	36.2 C L	04/04/14 03:32
Pulse Rate	105 H	04/04/14 03:32
Respiratory Rate	16	04/04/14 03:32
Blood Pressure	130/85	04/04/14 03:32
O2 Sat by Pulse Oximetry	99	04/04/14 03:32

Height	1.52 m
Weight	58.967 kg
Weight Measurement Method	Estimated by Patient

04/04/14 04:03

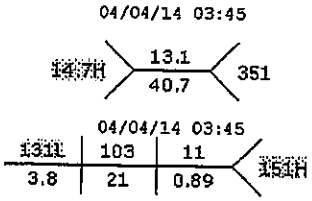
Vital Signs Reviewed?: Yes
Constitutional: Well Developed/Nourished
Eyes: PERRL, EOMI
Ears/Nose/Mouth/Throat: Nml ENT Exam. No: Meningismus, JVD
Cardiovascular: Regular Rate & Rhythm, Peri Pulses Strg/Eq. No: Murmur
Respiratory: BS Normal/Equal Bilat. No: Respiratory Distress, Wheezing
Gastrointestinal: Soft, Tender, Normal BS, Right CVAT. Not: Splenomegaly
Abdominal Tenderness: Present, RUQ. Not: Rebound, Voluntary Guarding
Musculoskeletal: Full ROM, Supple Neck. No: Deformity, Tenderness to Palp, Pedal Edema
Integumentary: Normal, Dry
Neurological: Alert, Oriented x 3, Normal Coordination, Normal Gait. Not: Focal

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Findings
Psychiatric: Nml Age Behavior, Alert
Hema/Lymph/Immun: No: Bleeding Gums, Lymphadenopathy

Results/Interpretations

- Laboratory
Result Note:



Laboratory Tests

	04/04/14 03:45	04/04/14 03:50	Range/Units
WBC	14.7 H		(3.8-11.2) 10(9)/L
RBC	4.52		(3.9-5.2) 10(12)/L
Hgb	13.1		(11.6-15.1) g/dL
Hct	40.7		(34.1-44.2) %
MCV	90.2		(80-100) fL
MCH	29.1		(27-33) pg
MCHC	32.2		(32-36) g/dL
RDW	13.4		(11-15) %
Plt Count	351		(150-450) 10(9)/L
Neut %	53		(40-70) %
Lymph %	38		(20-45) %
Mono %	7		(4-10) %
Eos %	1		(0-6) %
Baso %	1		(0-2) %
Differential Method	Auto		(())
Absolute Neutrophils	7.90 H		(1.4-7.0) 10(9)/L
Absolute Lymphocytes	5.50 H		(0.7-4.5) 10(9)/L
Absolute Monocytes	1.10 H		(0.1-1.0) 10(9)/L
Absolute Eosinophils	0.10		(0-0.6) 10(9)/L
Absolute Basophils	0.10		(0-0.2) 10(9)/L
Sodium	131 L		(133-145) mmol/L
Potassium	3.8		(3.3-5.1) mmol/L
Chloride	103		(96-108) mmol/L
Carbon Dioxide	21		(21-31) mmol/L
Anion Gap	7		(4-16)
BUN	11		(8-24) mg/dL
Creatinine	0.89		(0.40-1.10) mg/dL
Est GFR (Non-Af Amer)	>60		(>59)
Est GFR (MDRD) Af Amer	>60		(>59)
Glucose	151 H		(70-99) mg/dL
Calcium	8.7		(8.6-10.3) mg/dL
Total Bilirubin	0.8		(0-1.2) mg/dL

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

AST	138 H		(0-31) U/L
ALT	82 H		(0-31) U/L
Alkaline Phosphatase	74		(34-104) U/L
Total Protein	6.5		(5.9-8.4) g/dL
Albumin	4.1		(4.0-5.1) g/dL
Globulin	2.4		(2.0-3.6) g/dL
Albumin/Globulin Ratio	1.7		(1.2-2.3)
Lipase	232 H		(4-58) U/L
Urine Color		Yellow	(())
Urine Appearance		Hazy	(())
Urine pH		6.0	(5.0-7.5)
Ur Specific Gravity		1.021	(1.005-1.03)
Urine Protein		Negative	(NEG) mg/dL
Urine Glucose (UA)		Negative	(NEG) mg/dL
Urine Ketones		Negative	(NEG) mg/dL
Urine Blood		Mod H	(NEG)
Urine Nitrate		Negative	(NEG)
Urine Bilirubin		Negative	(NEG)
Urine Urobilinogen		0.2	(0.2-1.0) EU/dL
Ur Leukocyte Esterase		Negative	(NEG)
Urine RBC		0	(0-2) /hpf
Urine WBC		10-20	(0-5) /hpf
Ur Squamous Epith Cells		Mod	(()) /lpf
Urine Bacteria		Few H	(NONE) /hpf
Urine Mucus		Mod	(()) /lpf
Ur Culture Indicated?		Reflex c/s not done.	(CSND)
Urine HCG, Qual		Negative	(())

- CT Scan
** CT # 1
CT Notes:

04/04/14 06:00
CAT scan of the abdomen and pelvis without contrast shows left nephrolithiasis and mild left hydronephrosis secondary to a stone 1.3mm in the proximal left ureter just distal to the UPJ mildly prominent distal small bowel contain content suggesting ileus

Update

- Patient Update
Visit Medications:

ED Visit Medications

Generic Name Trade Name	Dose Route Freq PRN Reason	Start Stop	Last Admin Dose Admin
Lactated Ringer's Lactated Ringers Iv Bag	1,000 mls @ 200 mls/ hr IV .Q5H ONE	04/04/14 03:56 04/04/14 08:55	04/04/14 04:00 200 mls/hr Administration

Discontinued Medications

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Generic Name Trade Name	Dose Route Freq PRN Reason	Start Stop	Last Admin Dose Admin
Ciprofloxacin Cipro Tablet	500 mg PO ONCE ONE	04/04/14 06:03 04/04/14 06:04	04/04/14 06:20 500 mg Administration
Hydromorphone HCl Dilaudid Injection	0.5 mg IVP ONCE ONE	04/04/14 04:51 04/04/14 04:52	04/04/14 04:59 Not Given
Hydromorphone HCl Dilaudid Injection	0.5 mg IV ONCE ONE	04/04/14 04:58 04/04/14 04:59	04/04/14 04:59 0.5 mg Administration
Ketorolac Tromethamine Toradol Injection	30 mg IV ONCE ONE	04/04/14 03:56 04/04/14 03:57	04/04/14 04:00 30 mg Administration
Morphine Sulfate Morphine Injection	2 mg IVP ONCE ONE	04/04/14 04:44 04/04/14 04:45	04/04/14 04:50 Not Given
Ondansetron HCl Zofran Injection	4 mg IVP ONCE ONE	04/04/14 03:44 04/04/14 03:45	04/04/14 03:45 4 mg Administration
Oxycodone/Acetaminophen Percocet 5/325mg Tablet	1 each PO ONCE ONE	04/04/14 06:21 04/04/14 06:22	04/04/14 06:21 1 each Administration

- Disposition
If pending items are cleared: May Go Home

Medical Decision Making/Dispo
MDM Note/Critical Care Macro:
04/04/14 06:06
Based on my history, physical exam, and diagnostic evaluation, the patient appears to have symptoms consistent with acute ureteral colic and nephrolithiasis without acute UTI. The pain appears to be secondary to ureteral colic. Pt's pain is now well controlled after treatment with [analgesia IV]. Pt will be discharged with narcotic analgesics and will be discharged with instructions to return if increasing pain, weakness, fevers, or new symptoms. I encouraged follow-up with the primary care physician for repeat exam in 24-48 hours. Pt was also given a referral to an area urologist. She will be kept on Cipro. She did have white cells in the urine.

04/04/14 06:27

Reviewed the Following: Lab, Imaging
Discussed Investigation, Dx and Tx With: Patient
Risk, Follow-up Discussed With: Patient
Referrals:
Leeloy,Henry K., MD [Primary Care Provider] - 3 to 5 Days
Ambulatory Prescriptions:
Ciprofloxacin HCl [Cipro 500 mg Tab*] 500 mg PO Q12H #10 tablet
Hydrocodone/Acetaminophen [Vicodin 5-300Mg Tablet] 1 each PO Q6HP PRN #14 tablet
PRN Reason:
Ondansetron [Zofran ODT Tab] 4 mg PO Q6H #14 tablet
Forms: Other Return to Work/School

- Disposition

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Time of Disposition: 06:06
Disposition: DC
DX: (Primary DX listed 1st):
Renal colic on left side, Nephrolithiasis, Abdominal pain
Condition: Good
Instructions: General Emergency Department Discharge Instructions, Renal Colic (ED)

Signed By: **Sarubbi, Jo Ann MD** Date/Time: **04/05/14 1851**
<Electronically signed by Jo Ann Sarubbi MD>

CC: Leeloy, Henry K. MD.

East Hawaii Region

HIM ROI LAB RESULTS

Page: 1
Date: 04/24/14 14:13

VANHOUTEN,EVERINE A
Fac: Hilo Medical Center
34 F 0[redacted]
Attending:
Reason:

Loc:Emergency Department
Med Rec Num[redacted]

Bed:-
Visit:[redacted]
Reg Date:04/04/14

Lab Results

	04/04/14 03:50	04/04/14 03:45
WBC		14.7 H
RBC		4.52
Hgb		13.1
Hct		40.7
MCV		90.2
MCH		29.1
MCHC		32.2
RDW		13.4
Plt Count		351
Neut %		53
Lymph %		38
Mono %		7
Eos %		1
Baso %		1
Differential Method		Auto
Absolute Neutrophils		7.90 H
Absolute Lymphocytes		5.50 H
Absolute Monocytes		1.10 H
Absolute Eosinophils		0.10
Absolute Basophils		0.10
Sodium		131 L
Potassium		3.8
Chloride		103
Carbon Dioxide		21
Anion Gap		7
BUN		11
Creatinine		0.89
Est GFR (Non-Af Amer)		>60
Est GFR (MDRD) Af Amer		>60
Glucose		151 H
Calcium		8.7
Total Bilirubin		0.8
AST		138 H
ALT		82 H
Alkaline Phosphatase		74
Total Protein		6.5
Albumin		4.1
Globulin		2.4
Albumin/Globulin Ratio		1.7
Lipase		232 H
Urine Color	Yellow	
Urine Appearance	Hazy	
Urine pH	6.0	
Ur Specific Gravity	1.021	
Urine Protein	Negative	
Urine Glucose (UA)	Negative	
Urine Ketones	Negative	

Continued on Page 2

Urine Blood	Mod H	
Urine Nitrate	Negative	
Urine Bilirubin	Negative	
Urine Urobilinogen	0.2	
Ur Leukocyte Esterase	Negative	
Urine RBC	10-20	
Urine WBC	0	
Ur Squamous Epith Cells	Mod	
Urine Bacteria	Few H	
Urine Mucus	Mod	
Ur Culture Indicated?	Reflex c/s not done.	
Urine HCG, Qual	Negative	

Full Registration
Freq: Start: 04/04/14 03:26
Status: Discharge
Document 04/04/14 04:33 ABELANIO (Rec: 04/04/14 04:33 ABELANIO HLADTLT01)
Full Registration
Full registration complete? YES

FOOTNOTE 31

Hilo Medical Center
1190 WAIANUENUE AVE
HILO HI, 96720
(808) 932-3000

Diagnostic Imaging Report
Signed

Patient: **VANHOUTEN,EVERINE A**
Account: **HL0010249297**
Medical Record: **HM00507788**

DO[redacted]
Loc: **HLRAD**
Rm/Bd:

Age: **34**
Sex: **F**
Status: **REG CLI**

Exam: CT ABDOMEN AND PELVIS W/O
Accession: A0000229382
Reason For Exam: GROSS HEMATURIA
Ordering Physician: DeCaro, John MD

Service Date: **04/11/14**
Service Time: **1313**

PROCEDURE:
CT SCAN OF THE ABDOMEN AND PELVIS WITHOUT CONTRAST

CLINICAL HISTORY:
GROSS HEMATURIA

COMPARISON:
None.

TECHNIQUE:
Computed spiral tomography of the abdomen and pelvis was performed from the top of the diaphragms to the bottom of the pelvic floor using a multislice spiral CT scanner. This study was performed without intravenous or oral contrast in order to optimize visualization of the uroliths. The lack of oral and intravenous contrast somewhat decreases sensitivity of this examination for assessment of the solid viscera and bowel. If additional evaluation of these organs is desired, then contrast-enhanced CT with oral contrast should be considered. This study was done and no additional charge. After the noncontrast images were completed, contrast was noted in the collecting system from a contrast enhanced MRI done earlier today.

FINDINGS:
Lung bases: Lung bases are clear.

Liver: Unremarkable.

Gallbladder and bile ducts: The gallbladder is absent. There are no CT signs of biliary dilatation.

Pancreas: Unremarkable.

Spleen: Unremarkable.

Adrenal glands: Normal.

Aorta and retroperitoneum: Normal.

Kidneys, ureters, and bladder: The tiny left renal calculi noted on prior study are difficult to discern due to the contrast in the collecting system. There is a 2 mm stone anterior to the left psoas muscle at the level of the L3 superior endplate which appears to be within the proximal left ureter. This appears to be causing partial left ureteral obstruction as there is contrast in the distal left ureter.

Bowel and mesentery: Unremarkable.

Diagnostic Imaging Report

Signed

Patient: **VANHOUTEN,EVERINE A**
Account: **HL0010249297**
Medical Record: **HM00507788**

DOB: [redacted]
Loc: **HLRAD**
Rm/Bd:

Age: **34**
Sex: **F**
Status: **REG CLI**

Exam: CT ABDOMEN AND PELVIS W/O
Reason For Exam: GROSS HEMATURIA
Ordering Physician: DeCaro, John MD

Accesion:

Pelvic organs: IUD device is noted in the uterus.

Bones: No abnormality seen.

IMPRESSION:
Findings suspicious for a tiny 2 mm proximal left ureteral stone causing partial ureteral obstruction. This could be the cause of the patient's hematuria. If clinically indicated, the CT abdomen pelvis hematuria protocol study which has been rescheduled can be canceled.

Dictated at HMC.

This report was electronically signed by Dr. David Camacho on 4/11/2014 3:49 PM.

CC:<DeCaro, John MD; Leeloy, Henry K. MD>

Hilo Medical Center
1190 WAIANUENUE AVE
HILO HI, 96720
(808) 932-3000

Diagnostic Imaging Report
Signed

Patient: **VANHOUTEN,EVERINE A**
Account: **HL0010248972**
Medical Record: **HM00507788**

DOB: [redacted]
Loc: **HLRAD**
Rm/Bd:

Age: **34**
Sex: **F**
Status: **REG CLI**

Exam: MRI ABD W/WO CONT
Accession: A0000229351
Reason For Exam: VAGUE WEDGE SHAPED AREA OF RELATIVELY DECREASED DENSITY RT LIVER
Ordering Physician: Leeloy, Henry K. MD

Service Date: **04/11/14**
Service Time: **1200**

PROCEDURE:
MRI OF THE ABDOMEN WITH AND WITHOUT CONTRAST

CLINICAL HISTORY:
VAGUE WEDGE SHAPED AREA OF RELATIVELY DECREASED DENSITY RT LIVER

COMPARISON:
MR abdomen 7/16/2013 and CT abdomen pelvis dated 4/4/2014.

TECHNIQUE:
Magnetic resonance imaging of the abdomen was performed with and without contrast using 1.5 Tesla GE MRI unit. 13 cc of gadolinium contrast was given intravenously.

FINDINGS:
Liver: In the area of concern, at the anterior aspect of the right hepatic lobe, the wedge-shaped focus of hypodensity on prior CT appears to represent areas of focal fatty liver infiltration. No mass is seen in this area. However, there are 2 subtle foci of T1 hypointensity and T2 hyperintensity in the left hepatic lobe. After contrast administration, these nodules are well-defined and intensely enhance on the arterial phase with lobulated contours and measure 2.4 cm. On the venous phase each nodule is more difficult to appreciate. On the in phase and out of phase images, both nodules remain hypo-intense. Neither nodule can be clearly seen on prior CT studies, but identified on prior MRI of the abdomen dated 7/16/2013.

Gallbladder and bile ducts: The gallbladder is not seen.

Pancreas: Unremarkable.

Spleen: Normal.

Aorta: Normal.

Kidneys: Unremarkable.

Adrenal glands: Normal.

IMPRESSION:
The wedge shaped area of CT hypodensity within the right hepatic lobe represents an area of fatty liver infiltration. No further workup is necessary.
The two oval 2.4 cm left hepatic nodules are better defined on today's exam but were present on prior study of 7/16/2013 have not changed. These likely represent benign degenerating or dysplastic liver nodules. I would suggest a followup liver ultrasound in 6-12 months.

Diagnostic Imaging Report

Signed

Patient: **VANHOUTEN,EVERINE A** DOB [redacted] Age: **34**
Account: **HL0010248972** Loc: **HLRAD** Sex: **F**
Medical Record: **HM00507788** Rm/Bd: Status: **REG CLI**

Exam: MRI ABD W/WO CONT Accesion:
Reason For Exam: VAGUE WEDGE SHAPED AREA OF RELATIVELY DECREASED DENSITY RT LIVER
Ordering Physician: Leeloy, Henry K. MD

Dictated at HMC.

This report was electronically signed by Dr. David Camacho on 4/11/2014 1:30 PM.

CC:<Leeloy, Henry K. MD; Leeloy, Henry K. MD>

FOOTNOTE 32

PATIENT REGISTRATION FORM
HILO MEDICAL CENTER
1190 WAIANUENUE AVE HILO HI 96720

MED REC#: [redacted] NAME: VANHOUTEN,EVERINE A VIP CONF

ACCOUNT#: [redacted]
BIRTHDATE: [redacted] ADMIT DATE: 04/23/14 TIME: 2143 DISCHG DATE:
AGE: 34 SERV/LOC: HLED SOC SEC#: XXX-XX-3768
SEX: F ROOM/BED: PAT STATUS: DEP ER
FIN CLASS: HMSA RACE: WHITE/CAUCASIAN ADM CLERK: KBROWN2
INS DIAG: ADMIT SOURCE: PATIENT CAME FROM HO
INS AUTH: REASON:
INS Procedure 1: Proc 2: Proc 3: Proc 4:

*** PATIENT INFORMATION ***

PATIENT: VANHOUTEN,EVERINE A MARITAL ST: NEVER MARRIED
ADDRESS: [redacted] RELIGION: NONE

[redacted]
PHONE HM#: [redacted] PHONE WK#: [redacted]
PREFERRED LANGUAGE: English

*** PHYSICIAN INFORMATION ***

PRIMARY CARE PHYS: Leeloy, Henry K. MD. FAMILY PHYS:
ADMIT PHYSICIAN: OTHER PHYS:
ATTENDING/ER PHYS: Sarubbi, Jo Ann MD

*** CONTACT INFORMATION ***

NEXT OF KIN: NONE,PERPT PERSON TO NOTIFY: VANHOUTEN,BARBARA
NOK ADDRESS: PERSON NOTIFY ADD:

NOK PHONE #: PERSON NOTIFY PH#: [redacted]
NOK OT PH #: PERSON OT PH#:

*** GUARANTOR INFORMATION ***

GUARANTOR NAME: VANHOUTEN,EVERINE A GUAR EMPLOYER: HILO MEDICAL CENTER
GUAR ADDRESS: [redacted] GUAR EMP PH #: [redacted]
RELATIONSHIP: PATIENT
GUAR PHONE NO: [redacted] GUARANTOR SS#: XXX-XX-3768

INSURANCE	POLICY #	GROUP #	SUBSCRIBER
1 HMSA PO Box 32700,Honolulu,HI 96803 (800)790-4672	[redacted]	690	VANHOUTEN,EVERINE A
2			
3			

*** ADVANCE DIRECTIVES ***

Advanced Directive:U Name:
What type:

Do you have a living will?
HIPAA Notice Provided? 07/05/13 COA signed? Y If no?

COMMENT:

HIE-CM01

Hilo Medical Center
We Care for Our Community
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)932-3000

Report Status: Signed

Patient: **VANHOUTEN,EVERINE A**
DOB: [redacted]
Medical Record: **HM00507788**
Account: **HL0010251413**
PCP: **Henry K. Leeloy MD**
ED Provider: **Sarubbi, Jo Ann MD**
Service Date: **04/23/14**

History of Present Illness
Nursing Note: Agreed With
Chief Complaint: Abdominal Pain
Time Seen by Provider: 04/23/14 22:02
Source: Patient, Hospital Records
Historian: Appears accurate
Exam Limitations: None
Notes: (location/quality/context):

Nursing Triage Note

History of Chief Complaint nausea. Pt denies

Pt c/o epigastric abd pain x20min. + states she knows she has kidney stones, flank pain

04/23/14 22:29
This is a 35 year old female patient of Dr. Leeloy and Dr. Hartman with a PMHx of migraines and possible choledocholithiasis [Endoscopic retrograde cholangiopanc on 8/07/13], kidney stones, and anxiety who presents to the ED today alone via POV complaining of epigastric abdominal pain. Symptoms began earlier this evening. The patient reports that her pain is severe, constant and worsening. It is primarily located to her epigastrium but radiates into her back. She reports to having nausea but is otherwise without complaints. She denies any vomiting, diarrhea, chest pain, shortness of breath, urinary symptoms or any other associated symptoms or traumas.

04/23/14 22:31
Scribed by Corey Eshpeter.

Onset: Hours
Severity: Severe
Timing/Duration: Constant, Worsening
Modifying Factors: improves with: Other (None)
Associated Symptoms: Nausea/Vomiting (NO VOMITING). denies: Chest Pain, Fever/Chills, Shortness of Breath
Allergies/Adverse Reactions:

No Known Allergies Allergy (Verified 04/04/14 03:32)

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Home Medications:

Medication	Instructions	Recorded	Type
Hydrocodone/Acetaminophen [Vicodin 5-300Mg Tablet]	1 each PO Q6HP PRN #14 tablet	04/04/14	Rx

- History of Present Illness Notes
Note::

04/23/14 22:31
Scribed by Corey Eshpeter.

Past Medical History
Past Medical History: Reports: Other (Migraines; Possible choledocholithiasis w/ERC performed on 8/07/13). Denies: Asthma, DM, HTN
Past Surgical History: Cholecystectomy, Other (Breast augmentation)

- Social History
Personal History: Employed (HMC)
Alcohol: Reports: Never
Drugs: Reports: Never
Smoking Status: Never Smoker

- Past Medical History Notes
Note::

04/23/14 22:31
Scribed by Corey Eshpeter.

Review of Systems
Except as noted: Reviewed and negative
Constitutional: denies: Fever, Chills
Cardiovascular: denies: Chest Pain
Respiratory: denies: Dyspnea, Cough
Gastrointestinal: Abdominal Pain, Nausea. denies: Vomiting
Genitourinary: denies: Dysuria, Hematuria
Musculoskeletal: Back Pain
Neurological: denies: Headache

- Review of Systems Notes
Note::

04/23/14 22:31
Scribed by Corey Eshpeter.

Physical Exam
Nursing Vital Signs:

Initial Vital Signs

Temperature	36.9 C	04/23/14 22:02

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Pulse Rate	71	04/23/14 22:02
Respiratory Rate	16	04/23/14 22:02
Blood Pressure	129/79	04/23/14 22:02
O2 Sat by Pulse Oximetry	100	04/23/14 22:02

Height	1.52 m
Weight	54.431 kg
Weight Measurement Method	Estimated by Patient

Vital Signs Reviewed?: Yes
Constitutional: Well Developed/Nourished, Distress (and crying), Appears Stated Age, Alert
Eyes: PERRL, EOMI
Ears/Nose/Mouth/Throat: Nml ENT Exam, Nml Thyroid. No: Nodes, JVD
Cardiovascular: Regular Rate & Rhythm, Peri Pulses Strg/Eq. No: Murmur
Respiratory: BS Normal/Equal Bilat. No: Respiratory Distress, CW Tenderness to Palp, Wheezing, Crackles
Gastrointestinal: Soft, Normal BS
Abdominal Tenderness: Present, Epigastric. Not: Rebound, Voluntary Guarding, Involuntary Guarding
Musculoskeletal: Full ROM, Supple Neck. No: Deformity, Tenderness to Palp, Pedal Edema
Integumentary: Normal, Dry
Neurological: Alert, Oriented x 3. Not: Focal Findings
Psychiatric: Nml Age Behavior, Nml Mood/Affect, Alert
Hema/Lymph/Immun: No: Bleeding Gums, Lymphadenopathy

- Physicial Exam Notes:
Note::

04/23/14 22:31
Scribed by Corey Eshpeter.

Results/Interpretations

- Laboratory
Result Note:

04/23/14 22:00

9.5	13.2	403
	39.6	

04/23/14 22:00

138	105	9	72
3.8	28	0.86	

Laboratory Tests

	04/23/14 22:00	Range/Units
WBC	9.5	(3.8-11.2) 10(9)/L

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

RBC	4.46	(3.9-5.2) 10(12)/L
Hgb	13.2	(11.6-15.1) g/dL
Hct	39.6	(34.1-44.2) %
MCV	88.8	(80-100) fL
MCH	29.6	(27-33) pg
MCHC	33.3	(32-36) g/dL
RDW	13.0	(11-15) %
Plt Count	403	(150-450) 10(9)/L
Neut %	45	(40-70) %
Lymph %	44	(20-45) %
Mono %	8	(4-10) %
Eos %	2	(0-6) %
Baso %	1	(0-2) %
Differential Method	Auto	(())
Absolute Neutrophils	4.20	(1.4-7.0) 10(9)/L
Absolute Lymphocytes	4.20	(0.7-4.5) 10(9)/L
Absolute Monocytes	0.80	(0.1-1.0) 10(9)/L
Absolute Eosinophils	0.20	(0-0.6) 10(9)/L
Absolute Basophils	0.10	(0-0.2) 10(9)/L
Sodium	138	(133-145) mmol/L
Potassium	3.8	(3.3-5.1) mmol/L
Chloride	105	(96-108) mmol/L
Carbon Dioxide	28	(21-31) mmol/L
Anion Gap	5	(4-16)
BUN	9	(8-24) mg/dL
Creatinine	0.86	(0.40-1.10) mg/dL
Est GFR (Non-Af Amer)	>60	(>59)
Est GFR (MDRD) Af Amer	>60	(>59)
Glucose	72	(70-99) mg/dL
Calcium	9.0	(8.6-10.3) mg/dL
Total Bilirubin	0.4	(0-1.2) mg/dL
AST	36 H	(0-31) U/L
ALT	24	(0-31) U/L
Alkaline Phosphatase	80	(34-104) U/L
Total Protein	6.5	(5.9-8.4) g/dL
Albumin	4.4	(4.0-5.1) g/dL
Globulin	2.1	(2.0-3.6) g/dL
Albumin/Globulin Ratio	2.1	(1.2-2.3)
Lipase	32	(4-58) U/L

Update

- Patient Update
Status on patient:
04/23/14 22:28
Charting performed by ED scribe Corey Eshpeter for Dr.Sarubbi.

04/24/14 00:42
According to the patient's old records. She has had right sided abdominal pain has been ongoing over a year She's had workup including M. ERCP and CAT scan did not show any etiology for the pain. She does have a new the diagnosis of liver, lesion. That's being worked up. She is scheduled for her lithotripsy for her left ureteral and kidney

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

stone
Visit Medications:

ED Visit Medications

Discontinued Medications

Generic Name Trade Name	Dose Route Freq PRN Reason	Start Stop	Last Admin Dose Admin
Glycopyrrolate Robinul Injection	0.1 mg IV ONCE ONE	04/24/14 00:39 04/24/14 00:40	04/24/14 00:50 0.1 mg Administration
Hydromorphone HCl Dilaudid Injection	1 mg IVP ONCE ONE	04/24/14 00:39 04/24/14 00:40	04/24/14 00:50 1 mg Administration
Ketorolac Tromethamine Toradol Injection	30 mg IV ONCE ONE	04/23/14 23:13 04/23/14 23:14	04/23/14 23:21 30 mg Administration
Lorazepam Ativan Injection	0.5 mg IV ONCE ONE	04/23/14 22:30 04/23/14 22:31	04/23/14 22:44 0.5 mg Administration
Morphine Sulfate Morphine Injection	4 mg IVP ONCE ONE	04/23/14 22:29 04/23/14 22:30	04/23/14 22:44 4 mg Administration
Ondansetron HCl Zofran Injection	4 mg IVP ONCE ONE	04/23/14 22:29 04/23/14 22:30	04/23/14 22:44 4 mg Administration

Medical Decision Making/Dispo
MDM Note/Critical Care Macro:
04/24/14 01:20
All medical record entries made by the scribe were at my direction. I have reviewed the chart and agree that the record accurately reflects my personal performance of the history, physical exam, medical decision making, and the emergency department course for this patient. I have also personally reviewed and agree with the discharge instructions and disposition.
Patient presents to the emergency department with abdominal pain. After history, physical exam, and diagnostic evaluation, the etiology for their pain is unclear. In the emergency department they received [morphine and Dilaudid Zofran IV]. Laboratory data was nondiagnostic. White blood cell count was unremarkable. On serial exam their pain improved. At this point it is unclear exactly the etiology of the pt's pain; but I think they are at low risk for significant abdominal pathology based on serial exams and our ED evaluation. The patient has had this chronic abdominal pain has been ongoing for a year. Her workup has been negative. The concern was for pancreatitis, but the patient's lipase was normal. She was not vomiting. She appeared comfortable Patient is advised to have a followup with their primary care physician tomorrow for a recheck and repeat abdominal exam. They were advised to return to the emergency department if significant pain, fevers, not tolerating oral food or fluid, or new complaints

04/24/14 01:23

Reviewed the Following: Lab, Old Charts
Discussed Investigation, Dx and Tx With: Patient
Risk, Follow-up Discussed With: Patient
Referrals:
Leeloy,Henry K., MD [Primary Care Provider] - 2 Day
Pg 5 of 6
Physician Documentation 0423-0149

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

- Disposition
Time of Disposition: 01:09
Disposition: DC
DX: (Primary DX listed 1st):
Chronic abdominal pain, Nephrolithiasis
Condition: Stable
Instructions: General Emergency Department Discharge Instructions, Abdominal Pain (ED)
Custom Instructions:
Follow up with your primary doctor this week for reevaluation, return to the emergency department as needed

- MDM Notes
Note::

04/23/14 22:33
Scribed by Corey Eshpeter.

Signed By: **Sarubbi, Jo Ann MD** Date/Time: **04/24/14 0124**
<Electronically signed by Jo Ann Sarubbi MD>

CC: Leeloy, Henry K. MD.

FOOTNOTE 33

Hilo Medical Center
1190 WAIANUENUE AVE
HILO HI, 96720
(808) 932-3000

Diagnostic Imaging Report
Signed

Patient: **VANHOUTEN,EVERINE A**
Account: **HL0010252945**
Medical Record: **HM00507788**

DO[redacted]
Loc: **HLRAD**
Rm/Bd:

Age: **34**
Sex: **F**
Status: **DEP CLI**

Exam: CT ABDOMEN AND PELVIS W/WO
Accession: A0000235186
Reason For Exam: GROSS HEMATURIA
Ordering Physician: DeCaro, John MD

Service Date: **05/06/14**
Service Time: **0800**

******** ADDENDUM #1 ********

Addendum:

Noncontrast images show punctate calcifications in the spleen best on coronal image 45 likely represent old granulomatous disease.

There are bilateral punctate renal cortical calcifications none of which are obstructive, largest in the left upper renal cortex largest measuring 3 mm.

This report was electronically signed by Dr. Christopher Neal on 5/7/2014 9:19 AM.

******** ORIGINAL REPORT ********
PROCEDURE:
CT SCAN OF THE ABDOMEN AND PELVIS WITH AND WITHOUT CONTRAST

CLINICAL HISTORY:
GROSS HEMATURIA

COMPARISON:
None.

TECHNIQUE:
. Precontrast CT spiral acquisition was made from the diaphragm through the liver. 75 cc of Omnipaque 350 iodinated contrast was then injected intravenously. After a 20 second delay, an acquisition was made from the dome of the liver through the iliac crests. After a 5 minute scan delay, another acquisition was made from the diaphragm through the inferior pubic rami.

FINDINGS:
Lung bases: Lung bases are clear. Bilateral implants.

Liver: Normal.

Gallbladder and bile ducts: Gallbladder surgically absent

Pancreas: Normal.

Spleen: Normal.

Diagnostic Imaging Report

Signed

Patient: **VANHOUTEN,EVERINE A**
Account: **HL0010252945**
Medical Record: **HM00507788**

DOB: [redacted]
Loc: **HLRAD**
Rm/Bd:

Age: **34**
Sex: **F**
Status: **DEP CLI**

Exam: CT ABDOMEN AND PELVIS W/WO
Reason For Exam: GROSS HEMATURIA
Ordering Physician: DeCaro, John MD

Accesion:

Adrenal glands: Normal.

Aorta and retroperitoneum: Normal.

Kidneys, ureters, and bladder: No evidence of stones or hydronephrosis.

Bowel and mesentery: No acute process. Appendix is normal in caliber.

Pelvic organs: IUD within the uterus.

Bones: No abnormality seen.

IMPRESSION:
No significant amounted detected. Specifically sought and not identified is any obvious source of the patient's known hematuria.

Dictated at HMC.

This report was electronically signed by Dr. Christopher Neal on 5/6/2014 10:06 AM.

CC:<DeCaro, John MD; Leeloy, Henry K. MD>

Hilo Medical Center
1190 WAIANUENUE AVE
HILO HI, 96720
(808) 932-3000

Diagnostic Imaging Report
Signed

Patient: **VANHOUTEN,EVERINE A**
Account: **HL0010252945**
Medical Record: **HM00507788**

DOB: [redacted]
Loc: **HLRAD**
Rm/Bd:

Age: **34**
Sex: **F**
Status: **REG CLI**

Exam: ABDOMEN 1V (KUB)
Accession: A0000235187
Reason For Exam: GROSS HEMATURIA
Ordering Physician: DeCaro, John MD

Service Date: **05/06/14**
Service Time: **0830**

PROCEDURE:
ABDOMEN 1 VIEW

CLINICAL HISTORY:
GROSS HEMATURIA

COMPARISON:
CT the abdomen pelvis today's date

TECHNIQUE:
Supine.

FINDINGS:
Bowel gas pattern: Normal.

Abdominal soft tissues: Contrast opacification the kidneys with segmental visualization of the ureters and partially opacified urinary bladder. IUD seen in lower pelvis.

Bones: No abnormality seen.

IMPRESSION:
Intravenous contrast in the genitourinary system and IUD. No definite acute intra-abdominal pathology detected

Dictated at HMC.

This report was electronically signed by Dr. Christopher Neal on 5/6/2014 8:35 AM.

CC:<DeCaro, John MD; Leeloy, Henry K. MD>

Hilo Medical Center
We Care for Our Community
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)932-3000

Report Status: Signed

Patient: **VANHOUTEN,EVERINE A**
DOB: [redacted]
Medical Record: **HM00507788**
Account: **HL0010254186**
PCP: **Henry K. Leeloy MD**
ED Provider: **Edwards, Robin MD**
Service Date: **05/09/14**

History of Present Illness
Nursing Note: Agreed With
Chief Complaint: Flank pain
Time Seen by Provider: 05/09/14 22:30
Source: Patient, Hospital Records
Historian: Appears accurate
Exam Limitations: None
Notes: (location/quality/context):

Nursing Triage Note

History of Chief Complaint FLANK AFTER YESTERDAY; PT HERE FOR EVALUATION OF PAIN TO LT STENT PLACEMENT FOR KIDNEY STONE NAUSEA; NOTED DISCOMFORT

05/09/14 22:31
This patient is a 34 year old female with a past medical history of migraines and kidney stones who presents to the ED with family via POV complaining of flank pain. Patient states that she had a left kidney stent placed yesterday by Dr. DeCaro. She notes worsening left flank pain that has worsened since approximately 1800. Patient states that she has had hematuria as well. No known drug allergies. PCP is Dr. Leeloy. urologist is Dr. DeCaro.

Scribed by Leif Marz

Onset: Hours
Severity: Moderate
Timing/Duration: Constant
Modifying Factors: improves with: Other (none)
Associated Symptoms: None
Allergies/Adverse Reactions:

No Known Allergies Allergy (Verified 05/09/14 22:11)

Home Medications:

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Medication	Instructions	Recorded	Type
Ciprofloxacin HCl [Cipro Tablet]	500 mg PO BID #20 tablet	05/09/14	Rx
Hydrocodone/Acetaminophen [Norco 5-325 Tablet]	1 each PO Q4HP PRN #12 tablet	05/09/14	Rx
Ondansetron [Zofran Odt Tablet]	4 mg PO Q4HP PRN #10 tablet	05/09/14	Rx

- History of Present Illness Notes
Note::

05/09/14 22:32
Scribed by Leif Marz

Past Medical History
Past Medical History: Reports: Other (Migraines; Possible choledocholithiasis w/ERC performed on 8/07/13). Denies: Asthma, DM, HTN
Past Surgical History: Cholecystectomy, Other (kdiney stent placement, breast augmentation)

- Family History
Significant Family History: None

- Social History
Personal History: Single
Alcohol: Reports: Never
Drugs: Reports: Never
Smoking Status: Never Smoker

- Past Medical History Notes
Note::

05/09/14 22:33
Scribed by Leif Marz

Review of Systems
Except as noted: Reviewed and negative
Constitutional: denies: Fever, Chills
Eyes: denies: Vision Change, Discharge
Ears/Nose/Mouth/Throat: denies: Earache, Sore Throat
Cardiovascular: denies: Chest Pain, Palpitations
Respiratory: denies: Dyspnea, Cough
Gastrointestinal: Abdominal Pain, Nausea. denies: Vomiting
Genitourinary: Dysuria. denies: Incontinence
Musculoskeletal: Back Pain (flank pain)
Integumentary: denies: Pruritis, Rash
Neurological: denies: Dizziness, Headache

- Review of Systems Notes
Note::

05/09/14 22:44

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Scribed by Leif Marz

Physical Exam
Nursing Vital Signs:

Initial Vital Signs

Temperature	36.8 C	05/09/14 22:11
Pulse Rate	94	05/09/14 22:11
Respiratory Rate	18	05/09/14 22:11
Blood Pressure	144/68 H	05/09/14 22:11
O2 Sat by Pulse Oximetry	100	05/09/14 22:11

Height 1.52 m
Weight 60.328 kg

Vital Signs Reviewed?: Yes
Constitutional: Well Developed/Nourished, Distress (acute), Appears Stated Age
Eyes: PERRL, EOMI
Ears/Nose/Mouth/Throat: Nml ENT Exam. No: JVD
Cardiovascular: Regular Rate & Rhythm, Peri Pulses Strg/Eq
Respiratory: BS Normal/Equal Bilat. No: Respiratory Distress
Gastrointestinal: Soft, Normal BS. Not: Tender
Abdominal Tenderness: Not: Present
Musculoskeletal: Full ROM. No: Deformity, Tenderness to Palp, Pedal Edema
Integumentary: Normal, Dry
Neurological: Alert. Not: Focal Findings
Psychiatric: Nml Age Behavior, Alert
Hema/Lymph/Immun: No: Bleeding Gums, Lymphadenopathy

- Physicial Exam Notes:
Note::

05/09/14 22:36
Scribed by Leif Marz

Results/Interpretations

- Laboratory
Result Note:

05/09/14 22:41
[redacted] 11.6 299
35.2

05/09/14 22:41
137 [redacted] 12 [redacted]
3.4 22 0.79

Laboratory Tests

	05/09/14	05/09/14	Range/Units

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

	22:41	22:45	
WBC	13.2 H		(3.8-11.2) 10(9)/L
RBC	3.94		(3.9-5.2) 10(12)/L
Hgb	11.6		(11.6-15.1) g/dL
Hct	35.2		(34.1-44.2) %
MCV	89.2		(80-100) fL
MCH	29.4		(27-33) pg
MCHC	33.0		(32-36) g/dL
RDW	13.6		(11-15) %
Plt Count	299		(150-450) 10(9)/L
Neut %	66		(40-70) %
Lymph %	28		(20-45) %
Mono %	6		(4-10) %
Eos %	0		(0-6) %
Baso %	0		(0-2) %
Differential Method	Auto		(())
Absolute Neutrophils	8.50 H		(1.4-7.0) 10(9)/L
Absolute Lymphocytes	3.70		(0.7-4.5) 10(9)/L
Absolute Monocytes	0.80		(0.1-1.0) 10(9)/L
Absolute Eosinophils	0		(0-0.6) 10(9)/L
Absolute Basophils	0.10		(0-0.2) 10(9)/L
Sodium	137		(133-145) mmol/L
Potassium	3.4		(3.3-5.1) mmol/L
Chloride	109 H		(96-108) mmol/L
Carbon Dioxide	22		(21-31) mmol/L
Anion Gap	6		(4-16)
BUN	12		(8-24) mg/dL
Creatinine	0.79		(0.40-1.10) mg/dL
Est GFR (Non-Af Amer)	>60		(>59)
Est GFR (MDRD) Af Amer	>60		(>59)
Glucose	100 H		(70-99) mg/dL
Calcium	8.1 L		(8.6-10.3) mg/dL
Total Bilirubin	0.5		(0-1.2) mg/dL
AST	41 H		(0-31) U/L
ALT	79 H		(0-31) U/L
Alkaline Phosphatase	78		(34-104) U/L
Total Protein	5.8 L		(5.9-8.4) g/dL
Albumin	3.5 L		(4.0-5.1) g/dL
Globulin	2.3		(2.0-3.6) g/dL
Albumin/Globulin Ratio	1.5		(1.2-2.3)
Urine Color		Red	(())
Urine Appearance		Bloody	(())
Urine pH		7.0	(5.0-7.5)
Ur Specific Gravity		1.020	(1.005-1.03)
Urine Protein		>=300 H	(NEG) mg/dL
Urine Blood		Large H	(NEG)
Urine Bilirubin		Mod H	(NEG)
Urine Ictotest		Not performed H	(NEG)
Ur Leukocyte Esterase		Large H	(NEG)
Urine RBC		>100	(0-2) /hpf
Urine WBC		20-50	(0-5) /hpf
Ur Squamous Epith Cells		Mod	(()) /lpf
Urine Bacteria		Mod H	(NONE) /hpf
Urine Mucus		Occ	(()) /lpf

Pg 4 of 7
Physician Documentation 0509-0158

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Ur Culture Indicated?		Reflex c/s done. H	(CSND)

- CT Scan
** Pelvic CT
CT Notes:

05/09/14 23:41
Conclusion: No acute intrapelvic process is identified

Update

- Patient Update
Status on patient:

05/09/14 22:44
Charting performed by ED scribe Leif Marz for Dr. Edwards.
Visit Medications:

ED Visit Medications

Discontinued Medications

Generic Name Trade Name	Dose Route Freq PRN Reason	Start Stop	Last Admin Dose Admin
Acetaminophen/ Hydrocodone Bitart Norco 5/325 Mg Tablet	1 each PO TAKEHOME ONE	05/09/14 23:53 05/09/14 23:54	05/10/14 00:02 1 each Administration
Ceftriaxone Sodium/ Dextrose Rocephin 1gm Premix Bag	1 gm IV ONCE ONE	05/09/14 23:38 05/09/14 23:39	05/09/14 23:47 1 gm Administration
Ciprofloxacin Cipro Tablet	500 mg PO ONCE ONE Protocol	05/09/14 23:45 05/09/14 23:46	05/10/14 00:03 500 mg Administration
Hydromorphone HCl Dilaudid Injection	1 mg IV ONCE ONE	05/09/14 22:30 05/09/14 22:31	05/09/14 22:36 1 mg Administration
Hydromorphone HCl Dilaudid Injection	1 mg IV ONCE ONE	05/09/14 23:41 05/09/14 23:42	05/09/14 23:41 0.5 mg Administration
Sodium Chloride Sodium Chloride 0.9% Bag	1,000 mls @ 999 mls/ hr IV .Q1H1M ONE	05/09/14 22:35 05/09/14 23:35	05/09/14 22:30 999 mls/hr Administration
Ketorolac Tromethamine Toradol Injection	30 mg IV	05/09/14 23:51 05/09/14 23:52	05/10/14 00:03 Not Given

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

	ONCE ONE		
Metoclopramide HCl Reglan Injection	10 mg IV ONCE ONE	05/09/14 22:36 05/09/14 22:37	05/09/14 22:46 10 mg Administration
Ondansetron HCl Zofran Injection	4 mg IVP ONCE ONE	05/09/14 22:35 05/09/14 22:36	05/09/14 22:35 4 mg Administration
Ondansetron HCl Zofran Odt Tablet	4 mg PO TAKEHOME ONE	05/09/14 23:53 05/09/14 23:54	05/10/14 00:02 4 mg Administration
Tamsulosin HCl Flomax Capsule	0.4 mg PO ONCE ONE	05/09/14 22:36 05/09/14 22:37	05/09/14 22:55 0.4 mg Administration

Medical Decision Making/Dispo
MDM Note/Critical Care Macro:
05/09/14 23:56

All medical record entries made by the scribe were at my direction. I have reviewed the chart and agree that the record accurately reflects my personal performance of the history, physical exam, medical decision making, and the emergency department course for this patient. I have also personally reviewed and agree with the discharge instructions and disposition.
patient presented with severe left flank pain. Two days ago she had a stent placed in the left kidney and ureter by Dr De Caro for 3 non obstructing stones in the left kidney. Her repeat CT today shows the stent in good position and no obstruction. She does have leuk esterase in her urine and 50 WBC per hpf. I have discussed this with Dr Tikhonenkov who is on call for Island urology. he recommends treating the patient with cipro as an outpatient and they will see her for followup on Monday; She was given rocephin 1gm IV and cipro 500mg PO. She was given aprescription for cipro 500 bid. She will return to ER for uncontrolled pain, vomiting or fever

05/10/14 03:19

Reviewed the Following: Lab, Imaging, Old Charts
Discussed Investigation, Dx and Tx With: Patient
Risk, Follow-up Discussed With: Patient
Referrals:
Leeloy,Henry K., MD [Primary Care Provider] - 2 Day (follow up Monday with Dr Leeloy or Dr DeCaro for urine culture results; Return for persistant vomiting or uncontrolled pain)
Ambulatory Prescriptions:
Ciprofloxacin HCl [Cipro Tablet] 500 mg PO BID #20 tablet
Hydrocodone/Acetaminophen [Norco 5-325 Tablet] 1 each PO Q4HP PRN #12 tablet
PRN Reason:
Ondansetron [Zofran Odt Tablet] 4 mg PO Q4HP PRN #10 tablet
PRN Reason: NAUSEA/VOMITING

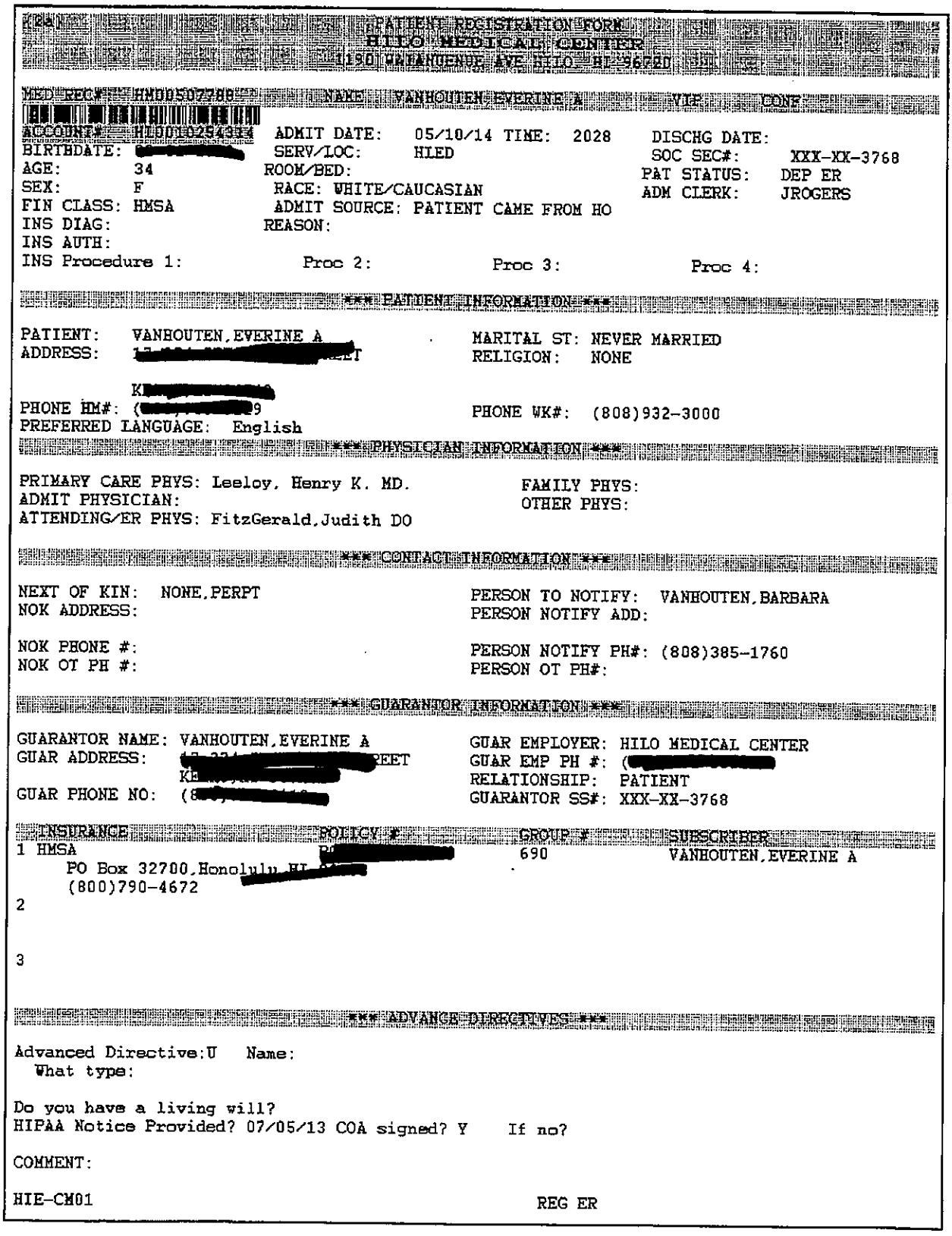
- Disposition
Time of Disposition: 00:30
Disposition: DC
DX: (Primary DX listed 1st):
Urinary tract infection, Calculus of kidney, Retained ureteral stent

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Condition: Stable
Instructions: General Emergency Department Discharge Instructions, Urinary Tract Infection in Women (ED)

Signed By: **Edwards, Robin MD** Date/Time: **05/10/14 0322**
<Electronically signed by Robin Edwards MD>

CC: Leeloy, Henry K. MD.



PATIENT REGISTRATION FORM
HILO MEDICAL CENTER
1190 WAIANUENUE AVE HILO HI 96720

MED REC#: HMD0507788 NAME: VANHOUTEN,EVERINE A VIP CONF

ACCOUNT#: HLO0102543[redacted] ADMIT DATE: 05/10/14 TIME: 2028 DISCHG DATE:
BIRTHDATE: [redacted] SERV/LOC: HILED SOC SEC#: XXX-XX-3768
AGE: 34 ROOM/BED: PAT STATUS: DEP ER
SEX: F RACE: WHITE/CAUCASIAN ADM CLERK: JROGERS
FIN CLASS: HMSA ADMIT SOURCE: PATIENT CAME FROM HO
INS DIAG: REASON:
INS AUTH:
INS Procedure 1: Proc 2: Proc 3: Proc 4:

*** PATIENT INFORMATION ***

PATIENT: VANHOUTEN,EVERINE A MARITAL ST: NEVER MARRIED
ADDRESS: [redacted] RELIGION: NONE

[redacted]
PHONE HM#: ([redacted]9 PHONE WK#: (808)932-3000
PREFERRED LANGUAGE: English

*** PHYSICIAN INFORMATION ***

PRIMARY CARE PHYS: Leeloy, Henry K. MD. FAMILY PHYS:
ADMIT PHYSICIAN: OTHER PHYS:
ATTENDING/ER PHYS: FitzGerald,Judith DO

*** CONTACT INFORMATION ***

NEXT OF KIN: NONE,PERPT PERSON TO NOTIFY: VANHOUTEN,BARBARA
NOK ADDRESS: PERSON NOTIFY ADD:

NOK PHONE #: PERSON NOTIFY PH#: (808)385-1760
NOK OT PH #: PERSON OT PH#:

*** GUARANTOR INFORMATION ***

GUARANTOR NAME: VANHOUTEN,EVERINE A GUAR EMPLOYER: HILO MEDICAL CENTER
GUAR ADDRESS: [redacted] GUAR EMP PH #: ([redacted]
RELATIONSHIP: PATIENT
GUAR PHONE NO: ([redacted] GUARANTOR SS#: XXX-XX-3768

INSURANCE	POLICY #	GROUP #	SUBSCRIBER
1 HMSA PO Box 32700,Honolulu HI [redacted] (800)790-4672	[redacted]	690	VANHOUTEN,EVERINE A
2			
3			

*** ADVANCE DIRECTIVES ***

Advanced Directive:U Name:
What type:

Do you have a living will?
HIPAA Notice Provided? 07/05/13 COA signed? Y If no?

COMMENT:

HIE-CM01 REG ER

Hilo Medical Center
We Care for Our Community
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)932-3000

Report Status: Signed

Patient: **VANHOUTEN,EVERINE A**
DOB: [redacted]
Medical Record: **HM00507788**
Account: **HL0010254314**
PCP: **Henry K. Leeloy MD**
ED Provider: **FitzGerald,Judith DO**
Service Date: **05/10/14**

NIH Stroke Scale

History of Present Illness
Source: Patient
Historian: Appears accurate
Exam Limitations: None
Onset: Days (Since stenting.)
Severity: Moderate
Timing/Duration: Constant
Associated Symptoms: Nausea/Vomiting (Nausea. No vomiting.). denies: Chest Pain, Cough, Fever/Chills, Shortness of Breath

<Lewis,Drew MD - Last Filed: 05/10/14 23:27>
Chief Complaint: Flank pain
Stated Complaint: Flank Pain
Notes: (location/quality/context):

Nursing Triage Note

History of Chief Complaint had in ed uti but no relief. symptoms.

pt here with c/o L flank pain where she stent placed for kidney stone. pt seen last night and started antibiotics for has been taking pain medications with denies fever, chills, or any other

05/10/14 21:53
34 yo female with history of recent renal stenting who presents with left flank pain.

Patient had ureteral stenting on Thursday. Discharged the same day. Was seen here last night for worsening flank pain. Had workup showing UTI, negative CT scan and mild leukocytosis. Since discharge last night she has continued to have left flank pain. Vicodin no seeming to help. Also with dysuria. Using pyridium without significant relief. No fevers. Nausea. No vomiting. Mild LLQ abdominal pain. (Lewis,Drew MD)

Allergies/Adverse Reactions:

No Known Allergies Allergy (Verified 05/10/14 20:46)

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

Home Medications:

Medication	Instructions	Recorded	Type
Ciprofloxacin HCl [Cipro Tablet]	500 mg PO BID #20 tablet	05/09/14	Rx
Hydrocodone/Acetaminophen [Norco 5-325 Tablet]	1 each PO Q4HP PRN #12 tablet	05/09/14	Rx
Ondansetron [Zofran Odt Tablet]	4 mg PO Q4HP PRN #10 tablet	05/09/14	Rx
Promethazine HCl [Phenergan Tablet]	12.5 mg PO Q4HP PRN #12 tablet	05/10/14	Rx

Past Medical History
Past Medical History: Reports: Other (Migraines; Possible choledocholithiasis w/ERC performed on 8/07/13). Denies: Asthma, DM, HTN

- Social History
Smoking Status: Never Smoker

<FitzGerald,Judith 05/10/14 20:55>
Past Surgical History: Other (Ureteral stenting.)

- Family History
Significant Family History: None

<Lewis,Drew MD - Last Filed: 05/10/14 23:27>

- Social History
Social History Notes:

05/10/14 23:22
Here with mom and brother. (Lewis,Drew MD)

Review of Systems
Constitutional: Chills. denies: Fever
Cardiovascular: denies: Chest Pain
Respiratory: denies: Dyspnea, Cough
Gastrointestinal: Abdominal Pain, Nausea, Other (Flank Pain.). denies: Vomiting
Genitourinary: Frequency, Dysuria
Neurological: denies: Dizziness, Headache

<Lewis,Drew MD - Last Filed: 05/10/14 23:27>

Physical Exam
Vital Signs Reviewed?: Yes
Constitutional: Well Developed/Nourished. Not: Distress
Eyes: PERRL, EOMI
Ears/Nose/Mouth/Throat: Nml ENT Exam